An Analysis of the Release of Information Function and the Cost of Copying Hospital Medical Records in the State of Ohio

A Project Sponsored by
The Ohio Health Information Management Association

January, 1994

TABLE OF CONTENTS

INTRODUCTION

What does it actually cost to copy a hospital medical record in the State of Ohio? Many of those unfamiliar with the process and requirements of copying a medical record believe that the fees charged are excessive. Those familiar with the process disagree. This controversy has surfaced in discussions on many pieces of legislation addressed in several different legislative committees.

As promised to the Speaker of the House of Representatives, an analysis was conducted of the actual costs involved in copying a medical record in the State of Ohio. John R. Hayes, an independent researcher, was commissioned by the Ohio Health Information Management Association to conduct the analysis. Mr. Hayes is the Coordinator of Research Information Services at the Wexner Institute for Pediatric Research at Children's Hospital in Columbus, Ohio.

Mr. Hayes' full report is contained in Appendix A. Key findings revealed that there was considerable variability among hospitals in the cost to copy a medical record. In accordance with the primary purpose of the medical record, hospitals responding to the survey did not bill for requests for medical records used for patient care purposes. Only 40 percent of the total records copied per year were copied for parties eligible to be billed (e.g. attorneys, insurance companies). Although survey respondents were not asked to explain the rationale for their fees charged to billable clientele, reported fees indicate that fee schedules are based on the entire cost of providing the copy function. Just as health care costs for certain segments of the population are not adequately reimbursed (e.g. Medicare, Medicaid, and other charity care) and are shifted to commercial third party payors, individuals with requests for medical records that do not have a direct impact on patient care are currently paying for the total cost of the copy function.

OVERVIEW OF CURRENT SITUATION

In order to fully comprehend the results and implications of the study, it is imperative that one understand the many differences between the processes that are required to produce medical record copies from those required of a local retail copy store. Costs to copy patient medical records are a result of a variety of factors:

- labor costs for verification of requests;
- labor and software costs for logging of requests;
- labor costs for record retrieval and copying;
- expense and capital costs for copying;
- expense costs for. mailing;
- postal costs for mailing;
- billing and bad-debt expenses;
- labor costs for refiling; and,
- space expenses.

Retail copy shops incur only the expense and capital costs for copying along with limited space expenses. When someone uses the retail copy store, the individual has, at his own expense, searched out the document he wishes to copy, and provided the labor to copy and deliver the item to the end user.

Processing Requirements

It is an accepted industry fact that over 20 steps or tasks have been identified as requirements to comply with the average request for health information. While the actual number of tasks may be defined and categorized differently across facilities, the tasks enumerated below provide a reasonable interpretation of the steps involved in processing each and every request for medical records in a hospital:

Mail pick-up/receipt/opening. The majority of requests for patient health information are received via the U.S. Postal Service. In most facilities, there is some type of mailroom function where the mail is received

and sorted by department. Department personnel either pick-up the mail in a designated location or it is delivered to the department by other hospital personnel. Once the mail is received in the department, it is opened and date stamped. The requests for health information are sorted from the other mail and given to the individual(s) responsible for processing release of information requests.

Logging of requests. Vital information such as the name of the requestor, patient's name, medical record number, and other identification is logged into the correspondence log. While many hospitals now maintain the log on some type of computer system, it is still found in paper format in many facilities. The correspondence log allows the department to handle phone calls and other questions regarding a request efficiently. It is not uncommon to receive follow-up phone calls from requestors asking when information was mailed out, to request additional information, to dispute charges, etc. This log maintains an up-to-th-minute status of each request received in the department.

Sorting of requests. Requests for health information are then sorted by type of request in accordance with workload prioritization and processing requirements (e.g.. patient care requests, requests affecting hospital accounts receivable, attorney requests, insurance company requests, etc.). Requests for health information for direct patient care receive the highest priority and are processed immediately.

Reviewing - authorization. All requests are reviewed to determine that appropriate authorization to release health information on the designated patient is present. The authorization must comply with state and federal laws and hospital policy. If the 3 authorization is not acceptable or present at all, correspondence from the hospital to the requesting party, and/or patient indicating such is necessary. It often takes many phone calls and letters before the proper authorization is obtained. Listed below are the citations in the law to which hospitals must comply:

Ohio Revised Code 3701.243. Release of information personnel must review each record to determine if the contents contain any mention of HIV testing, AIDS, or AIDS-related conditions. The Ohio Revised Code does not allow release of information on HIV testing, AIDS, or AIDS-related conditions unless a written release with specific language and contents as specified in the code is obtained. Releases must be accompanied by the statement, "This information has been disclosed to you from confidential records protected from disclosure by state law. You shall make no further disclosure of this information without the specific, written, and informed release of the individual to whom it pertains, or as otherwise permitted by state law. A general authorization for the release of medical or other information is not sufficient for the purpose of the release of HIV test results or diagnoses." Because of the privacy issue related to HIV and AIDS, records are not flagged in any way to designate this fact. Therefore, staff must read through numerous portions of the record, including the discharge summary, lab results, physician orders, and progress notes to be sure that there is no mention of AIDS or HIV before releasing copies of the record under a general authorization *(see Appendix B, pages Bl - B4).*

42 CFR Part 2. The confidentiality of alcohol and drug abuse treatment records is provided for by federal law and the procedure for disclosure is very detailed. Hospital personnel may disclose medical records according to the terms of the 4 patient's written consent. The consent must include specific requirements which include:

1) The specific name of the program or person permitted to make the disclosure;
2) The name of the individual or organization to which the disclosure is to made;
3) The name of the patient;
4) The purpose of the disclosure;
5) How much and what kind of information is to be disclosed;
6) The signature of the patient or authorized representative;
7) The date on which the consent is signed;
8) A statement that the consent is subject to revocation;
9) The date, event, or condition upon which the consent will expire if not revoke before.

As with HIV/AIDS records, each disclosure made with the patient's consent must be accompanied by the following written statement: "This information has been disclosed to you from records protected by

Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute an alcohol or drug abuse patient." *(See Appendix B, pages B5 - B24).*

Ohio Revised Code 5122.31. Ohio law also governs the release of psychiatric patients' records requiring a special consent from the patient or legal guardian that specifically denotes that records of psychiatric treatment are to be released. *(See Appendix B, pages B25 - B26).*

Ohio Revised Code 3701.74. Patients have rights under Ohio law to review and receive copied of their medical records from hospitals. In processing requests for releases of records that will go directly to patients, personnel must determine that disclosure of the record will not have an adverse effect on the patient. Staff must be knowledgeable of the circumstances and content of a record that could be damaging to the patient (i.e. psychiatric conditions, identification of a terminal illness, etc.) and seek the advice of the patient's physician prior to releasing the record. *(See Appendix B, pages B27 - B28).*

The Joint Commission on Accreditation of Healthcare Organizations standard IM.2 requires that hospitals develop and follow appropriate policies and procedures to ensure confidentiality and security of medical information. Personnel must thoroughly understand and follow those policies/procedures approved by the JCAHO. *(See Appendix B, page B29).*

Locating medical record numbers. Due to the high volume of medical records maintained in hospitals, patient records are filed by medical record number. This number is assigned at the time the patient presents to the facility for treatment and is usually maintained in a computer system. Hospitals that do not have the number in a computer system maintain the number in a card file. To locate the number, personnel enter the patient's name in the computer or search for the name in the card file. If there is not enough identifying information to obtain the medical record number (e.g. wrong name, misspelled name, inappropriate birthdate, inaccurate dates of treatment, etc.), correspondence to the requesting party is necessary. Depending on the nature of the request, correspondence questioning the identity of the patient may be via letter or telephone call.

Retrieving records. The medical record may be retrieved from any number of locations within the hospital, but personnel must first determine the current location of the record. While a central filing area is usually maintained in most facilities, the majority of records requested are in use elsewhere in the facility at the time of the request (e. g. nursing unit, quality review, physician completion area, etc.). Records that are very old may be stored off-site in a separate facility or may be on microfilm. In any event, the majority of records take much longer to locate than that of a simple walk to the fileroom.

Ensuring record completeness. Before releasing patient information, medical record personnel ensure that the record contains the necessary components to consider it complete. If the record is not complete, the process of having the physicians or other ancillary health professionals complete the record is accelerated. This includes corresponding by telephone, mail, and even chasing down the applicable person in the hospital during rounds. This step can take weeks, even months, depending upon the cooperation of the physician(s) involved. Correspondence to the requesting party to explain the delay becomes necessary and personnel spend time periodically checking to see if the medical record has been completed.

Determining the information requested. Each request is read thoroughly to determine what medical reports have been requested. Many times certain pieces of information are requested and personnel processing the request must be familiar with the contents of more than 100 forms to locate the information requested. In addition, most requests are vague and personnel must take extra time to determine what the requestor wants. Phone calls to requesting parties are often necessary.

Contacting hospital business office. Many times the hospital bill is requested along with other clinical patient information. In these instances, the hospital business office is contacted. Business office personnel must locate the proper patient file, pull the bill, copy the bill and forward the copy to the medical record department. The bill then has to be matched with the correct medical information.

Disassembling patient file. Based upon the determination made above as to the information being requested, the medical record is taken apart, separating the portions that need to be copied from the portions that do not.

Copying records. Portions of the record that must be copied are taken to the copy machine and copied. A high percentage of the record consists of forms of various sizes, colors, shapes, and weights which require the use of multiple features and adjustments of the copy machine to produce an acceptable copy. Many forms (e.g. monitor strips) are so unwieldy that they can only be reproduced by making copies of segments of the forms and taping the copies together to satisfy the requirements of the requestor. Trifold six-sided forms present similar problems in the duplication process. Appendix C of this report contains a small sampling of the types of forms which pose difficulties when producing copies. Not only are many of the forms in records cumbersome, records that are on microfilm require the manipulation of a microfilm reader-printer to produce copies. Each page of a microfilmed record must be centered and focused on the screen to ensure that an acceptable copy is produced.

Reassembling patient file. Due to the size and complexity of the medical record, each form contained within the record has a specific location or order in which it is filed. Once copies of the removed portions of the medical record are made, each original form must be filed into its appropriate location in the record. For future reference, a notation is made on the original request as to the date and what was copied.

Preparing certification letter. If the requesting party has asked for one, a letter of certification is typed and signed by the Director/Manager of Medical Records/Health Information. Some requests call for this letter to be notarized. Most hospitals have a notary somewhere within the facility but this still involves a trip to the notary and extra expense.

Preparing invoice. If the request is considered billable, an invoice is made out for the request. This requires personnel to count the number of pages copied, compute the charges, record hospital and patient identifying information on the invoice, and where Release of Information (R.O.I.) service companies are involved, compute the taxes.

Updating correspondence log. The correspondence log, as described earlier, is updated noting the final disposition of the request.

Preparing copies for mailing. Cover letters and invoices are attached and envelopes are addressed, stuffed, and sealed. In some instances, UPS and registered mail are utilized, requiring special tags to be completed and incurring additional costs.

Mailing copies. Most copies are dispersed through the hospital mailroom function. However, sometimes copies are taken directly to the post office or to a parcel service for timely dispersal.

Refiling the patient file. The record must be returned to the location from which it was obtained. This requires personnel to follow manual or computerized notations as to where the record should be returned.

Entering billing information. Depending on the sophistication and attention paid to collection of billed fees, either a manual or computerized tracking system providing the status of accounts receivable for medical record copies is maintained. Personnel enter information in this regard into a computer system or logbook.

Applying payments. As payments are received they are matched with the proper invoice and appropriate computer systems or logbooks are updated. Hospitals handling the entire correspondence function internally must correspond regularly with the Cashier's office, and Accounting Department and ensure that payments are credited to the appropriate hospital department.

Rebilling. If payment is not received in accordance with specifications, rebilling begins. This requires regeneration of an invoice. Depending upon the timeliness of the payment, the process may go on for months. Where R.O.I. service companies are involved, collection agencies may be engaged.

Customer service. Questions and problems arise from the requesting party which take time and correspondence to resolve. Compare the above described process with that which occurs when visiting a local retail copy store.

Only the step described above as "copying records" is required when one visits a local retail copy store. The majority of documents copied are on paper of a standard size and color which require little intervention to

obtain an acceptable copy. No special procedures have to be followed to determine if the request for copies is appropriate. The individual requesting the copy makes the determination, on an honor system, whether he is violating any copyright-protection rules.

Personnel Requirements

In health care facilities, credentialed medical record/health information management professionals, the administration, and the board of directors are charged with the duty to protect each patient's medical record from unauthorized access. This duty imposes the necessity to control, verify and monitor the access to patient records. Thereby, health care facilities are required to hire, train, and supervise staff; acquire and maintain the necessary equipment and software to perform the activity; and assign expensive square footage (designed to meet health care facility building code requirements) to this activity. Increasingly, medical record/health information management professionals face a dilemma: how to meet the needs of a variety of legitimate users of patient information while protecting patients from unauthorized, inappropriate, or unnecessary intrusion into the highly personal data in health records.

Complete, accurate health information must be readily available for patient care, but patients must be assured that the information they share with health care professionals will remain confidential. Without such assurance, patients may withhold critical information which could affect the quality and outcome of care, as well as the reliability of the information. Hospitals employ individuals with two or four-year degrees who have earned their credentials in medical record/health information management by passing a national examination to assure that all patient information is handled appropriately. To protect patient's privacy rights, each health care facility maintains, under the direction of the credentialed medical record/health information management specialists, policies and procedures for disclosure of health information.

To ensure consistent compliance with these policies and procedures, the American Health Information Management Association recommends to health care facilities that disclosure of health information be made only by those appropriately qualified to do so. In addition to a knowledge of the legal and confidentiality protection requirements, medical record/health information professionals must also be familiar with the clinical aspects of the record. For example, it is not unusual to receive a request for "copies of the material on the function of the heart". In this instance, the individual employed to process the request questions if he should copy the EKG report, the EKG tracings, the Holter monitor exam, the cardiac-catheterization typewritten report, the cardiac pre- and post-operative notes, the physician's examination of the chest and heart, or the daily routine blood pressure checks. While personnel do consult with requestors as to the documents necessary, the individual must be knowledgeable in the clinical area in order to ask the requestor the appropriate questions.

Charge structures

The tasks and procedures outlined above are required for each and every request for medical record copies, regardless of the number of pages requested. This represents a set of fixed costs. Due to these fixed costs associated with processing a request for medical information, fees for requests requiring only a minimal number of pages appear to be high. Hospitals, like any other business, must be able to recoup the costs associated with providing the service. Most fee structures specify an up front fee to cover the excessive fixed costs of processing any request, whether it is for one page or 1000 pages. Additional charges are then added based upon the number of pages copied.

Hospitals are in the business of patient care and as such, provide copies of medical records for continuity of care purposes free of charge. This practice ensures timely delivery of information necessary to provide quality patient care. Only those records obtained for business reasons or for purposes other than patient care have fees assessed. The fees charged are usually based upon the cost to provide ALL copies for ALL requests. Hospitals need to be able to cover the cost of providing the service in total, including the copies used directly for patient care, so as not to adversely impact the patient care process and increase costs.

Outsourcing

In the interest of efficiency and cost effectiveness, a high percentage of hospital services are outsourced to companies specializing in certain areas. Common outsourcing arrangements that hospitals are participating in today include food services, housekeeping services, transcription services, physical therapy, occupational therapy, and speech therapy services, materials management services, and shared information system arrangements. Many hospitals have also made a business decision to outsource or contract with a Release of Information (R.O.I.) service company to provide a portion or all of the copying coverage. Ten to fifteen years ago, the function of providing copies of medical records became problematic due to increased volume, over-regulation, and the continued need for confidentiality of the medical information being processed. Doctors, lawyers, patients, insurance companies, and other healthcare institutions were all requesting records. Extensive backlogs were common and each year the number of requests was increasing. At that time, the release of information function was traditionally operating at a financial loss to most institutions.

Release of Information service companies have sprung up across the country as a result of the need for hospitals to get the medical information processed in a timely and fiscally responsible manner, while continuing to protect the patients' confidentiality. Many hospitals, due to the inability to recruit, lack of funds or capital, problems managing fee collection, or backlogs or volume increases have chosen to contract with R.O.I. service companies. The individuals employed by the R.O.I. service company become, in essence, contracted agents for the hospital or health care facility and comply with the rules for release promulgated by state and federal regulations and the health care facility's policies.

Most commonly, use of R.O.I. service companies begins when backlogs occur, which results in an undue burden on the medical record/health information department. If a delay occurs in responding to requests, second and third requests are received from the r requestor, creating a ripple effect, resulting in an unmanageable situation. By contracting with R.O.I. service companies, the hospital can hold the service responsible for timely turnaround, while eliminating the additional staff that would be necessary to accomplish the tasks outlined earlier. The R.O.I. service company is responsible for processing and responding to all requests for health care facility record copies regardless of whether the service will be permitted to charge for it. R.O.I. service companies set charges as part of the free market system in which competition determines pricing.

Outsourcing decisions. If an outside company can make a profit at making copies of medical records, one questions why hospitals would choose to contract with an outside R.O.I. service company instead of deciding to make their internal operations more efficient and make a profit also. In making the decision to contract with outside resources, medical record/health information directors do examine internal operations first. R.O.I. service companies trying to secure contracts with hospitals provide time study analyses of how long it takes R.O.I. service company personnel to complete the tasks associated with the copy function. If hospital time studies indicate that the internal operations are less efficient and for various reasons it is determined that those processes cannot be made more efficient internally given the current staffing and budgetary limitations, it is more cost effective for the hospital to contract with an outside service.

R. O. I. service companies have achieved specialization in each and every facet of the copy function. Tasks often overlooked in internal hospital copy operations are the collection and customer service process. The typical hospital performing the copy function internally only receives 30 to 40 percent of the charges billed because adequate collection and customer service processes are not in place. R.O.I. service companies report that 25 to 35 percent of their time is spent in the collection/ customer service process with an average turnaround in accounts receivable of 45 days medical record/health information departments in hospitals are not staffed to manage this portion of the function appropriately.

Hospitals are always seeking ways to reduce expenses. R.O.I. service companies have demonstrated savings in terms of labor, materials, and supplies for medical record/health information departments. The dollars previously expensed for these items no longer appear in hospital budgets. Although most hospitals still have some revenue from the copy function in terms of retrieval fees paid by the R.O.I. service company the revenue numbers in hospital budgets for this function are usually reduced also. Since most hospitals have weak

collection/customer service processes for the copy function, the reduction in expenses through outsourcing outweighs the reduction in revenue.

ANALYSIS OF STUDY RESULTS

The purpose of this study was to provide information on the actual cost to copy a hospital medical record in the State of Ohio. The full report is contained in Appendix A. Surveys were distributed to 213 Ohio hospital medical record/health information department directors. Children's hospitals were excluded due to unavailability of key cost information derived from the Medicare Annual Cost Reports. One hundred twenty-four surveys were returned and considered valid for a 58.2 percent response rate. Due to the extreme variability of the data collected in all categories, medians were used for reporting purposes rather than averages. The median is that value above which half the values lie and below which the other half lie. The median is not often affected by extreme values, whereas the mean or average is. Survey responses were divided into two major groups; hospitals with R.O.I. service companies and hospitals without R.O.I. service companies. In addition, responses were categorized in accordance with the Medicare reimbursement classification system differentiating large urban, other urban, and rural hospitals. While there was considerable variability among individual hospitals responding even as hospitals with similar characteristics were grouped into categories, there was remarkable consistency among the medians of a number of divergent subgroups. The information gathered in the study is valid, even though several factors in the data collection process prohibit the reporting of the total cost to copy a medical record and the final results reveal an underestimated cost.

Key Computations

Key components computed to derive the results of this study included staffing, department operating costs, number of requests processed, number of pages per request, and percentage of billable copies. To assist in the understanding of each element critical to the study results, the data collection process for each of these components will be examined below:

Staffing. Department directors were asked to report the number of hours devoted to the copy or release of information function per week. While the department director can provide accurate data on the time spent on this function by department staff, the data collected on off-site external R.O.I. service company activities and other nondepartmental hospital personnel participating in the function was of questionable validity and not used in the computation. Therefore, the estimated time devoted to the copy function is underestimated in this study making the estimated cost lower than the actual cost. Median values of the proportion of staff dedicated to completing requests for information excluding staff from external R.O.I. service companies and non-departmental personnel were calculated and displayed in Appendix A, page 10, Table 1. The median value from all responses was that 5.3 percent of the department staff or cost was devoted to the copy function. Figures la and lb on page 11 of Appendix A demonstrate the variability in responses to this question with some hospitals devoting a much smaller or larger portion of their costs to this function. Staffing of the copy function has a direct relationship to the number of requests received by the individual department and the amount of resources that the individual hospital chooses to devote to that function. Just as in any other business, priorities for allocation of budgeted dollars differ from hospital to hospital with staffing of certain areas varying accordingly. Staffing decisions have a direct relationship on the level of service in terms of the quality of the service and the timeliness with which hospitals respond to requests. Those departments without adequate staffing struggle to provide the best service possible under the circumstances. See the section labeled "Available staff time" in Table 2 on page 16 of Appendix A for an enumeration of some of the comments regarding staffing concerns. As mentioned earlier, many departments with staffing concerns have sought the help of external R.O.I. service companies to ensure timely and quality service in this area.

Department Operating Costs. Direct and indirect costs of operating the medical record/health information department of each hospital were obtained from the Medicare Cost Reports for fiscal year 1992.

All hospitals that treat Medicare patients are responsible for submitting this report on an annual basis shortly following the close of their individual fiscal year. This report is subject to review by entities external to the hospitals through routine financial and Medicare audits and as such, was felt to be an accurate and reliable determinant of actual direct and indirect departmental costs. Figures 2a and 2b on page 11 of Appendix A show a high level of variability for this component with median values per category in Table 1 on page 10 of Appendix A ranging from a high of $1,708,983 to a low of $337,387 and an overall median of $813,328.

The cost to operate a medical record/health information department is directly related to the size, location, patient population, types of services provided, and third party payors served by the facility. Even though the study attempts to isolate a smaller range of variability through the Medicare reimbursement categorization, those facility specific factors mentioned above that are not considered by Medicare are causing a wide variance.

The way in which hospitals organize their medical record/health information service departments in terms of the functions each department may provide is also contributing to this variation. For example, one department may provide the major functions of release of information, medical record assembly, completion and storage, and transcription. On the other hand, another department may be organized to provide the above functions along with the additional functions of coding and abstracting, statistical reporting, birth certificate completion, utilization review, quality monitoring, and tumor registry maintenance, thus increasing the direct and indirect costs for the medical record/health information management department.

When this figure was used to calculate the estimated cost per copy request, each individual hospital's cost was calculated first based upon the numbers of department staff and the department cost per individual hospital, which equalizes the data for calculation and comparison. It was determined that approximately $43,106 was spent by each hospital on copying records ($813,328 times 0.053 of staff for copy function).

Requests processed. Table 1 on page 10 of Appendix A cites the median numbers of requests for copies based on the Medicare categorization with rural hospitals receiving the low median of 907 requests for 1992 and urban hospitals receiving the high median of 9385 requests. The median for all hospitals was 2285 requests. Department directors were asked to provide the number of requests received for 1992 and identify how they arrived at that number. Those responses that were simply guesses were not used in the calculations. Only those responses in which actual numbers from log books or computer systems or estimates made from a portion of a logbook were used to ensure validity.

The reported numbers reflect. all requests processed regardless of whether processed by hospital personnel or R.O.I. service company personnel. The scatter diagrams in Figures 3a and 3b on page 12 of Appendix A display the wide variation in the number of requests processed by the various departments. Again, the number of requests processed has a direct relationship to the number of requests received by the department. Requests for, medical information are driven by consumer demand. The third party payor mix, levels of service provided, and the general demographics of the patients treated at the facility have a great deal to do with the number of requests received for patient information.

Number of pages per request. Survey respondents were asked to identify the average number of pages per request. The median results are noted in Table 1 on page 10 of Appendix A and indicate median variation from a high of 22 pages in an urban hospital with an overall median of 17 pages. Once again, the variation between hospitals in this area is high as seen in Figures 5a and 5b on page 13 of Appendix A. Such variations are the result of the types of requests received and from whom, which is determined by the third party payor mix, levels of service provided, and the types of patients the facility treats.

In addition, many medical record/health information service departments structure and standardize policies and procedures for vague requests for information. For example, when a department receives a request for information that specifies "any and all information", it may have a policy that states that only the discharge summary and all reports dictated by a physician will be sent for each admission/visit specified which may only be six or seven pages per visit. At another facility, that same request may be processed by making a copy of the entire medical record, which could represent a request of 80 to 100 pages. Without receipt of specific

information from the requestor, the response to the request is left in the hands of the hospital. Table 2 on page 17 of Appendix A describes some of the concerns identified in the study regarding vague requests.

Percentage of billable requests. In responding to questions regarding the numbers of requests processed, department directors were asked to define the number of billable requests for 1992. Only the responses that indicated the figures were accurate because they were taken from log books or estimates derived from counts of a portion of the logbooks were used to determine the median percentage of 40.1.

As mentioned earlier, no hospital participating in the study charges for copies that are used for direct patient care. The 60 percent of non-billable requests include patient care requests along with requests from Medicare and Medicaid. The Medicare Peer Review Organization does pay hospitals 7 cents a page for copies of medical records and most hospitals do collect this minimal amount. However, since this payment does not begin to cover the cost of providing an average 80-page Medicare request, these requests were considered non-billable for the purpose of this study. The Medicaid Peer Review Organization also requests a significant number of medical record copies. There is no provision in Ohio law for hospitals to seek reimbursement for these copies. Therefore, hospitals do not bill the Ohio Department of Health or the peer review organization for the copies requested.

The Industrial Commission of Ohio pays hospitals a fixed reimbursement of $15 per request. Even though this fee is generally less than what would normally be billed according to a hospital's fee structure, for purposes of this study, "industrial" requests were considered billable requests.

Cost Estimates

Using the key computations discussed above, estimates of the "median" costs to copy a medical record to satisfy a request for information are presented in Table 1 on page 10 of Appendix A. Due to the variability in estimating one cost for all hospitals responding to the survey, the estimates are presented in percentile ranges. Figures 4a and 4b on page 13 of Appendix A illustrate the variability across all hospitals. The median cost of copying a 17-page medical record was $18.86 or $ l .11 per page.

In reviewing Table 1, dramatic differences in the cost per page between hospitals with R.O.I. service companies and hospitals without R.O.I. service companies are reported. Attributing to this difference is the fact that 1) there were more pages per request for the R.O.I. service company hospitals, and 2) the proportion of staff devoted to the copy function in R.O.I. service company hospitals excluded off-site activities performed by R.O.I. service company personnel. Therefore, the cost per page estimates ranging from 64 cents a page to 74 cents a page for hospitals with R.O.I. service, companies are underestimated. According to those responding to the question regarding time spent off-site by R.O.I. service companies, this cost is underestimated by at least 11 percent. However, it makes sense that those hospitals with R. O. I. service companies have lower actual costs than those without R.0.I. service companies. R.O.I. service companies specialize in photocopying medical records and, as mentioned earlier in this report, their specialty results in efficiency. The per page medians cited for hospitals without R.O.I. service companies are also underestimated due to not including hospital accounting functions and other activities of non-medical record staff. Going back to the outsourcing discussion concerning collection procedures on pages 13 - 15 of this report, one realizes that the $1.11 figure may be underestimated by 30 percent or more.

Annual Losses

Although it was explained above that the costs to copy a medical record in this study are underestimated, for purposes of this next discussion, let us assume that the cost of $1.11 per page was agreed upon as a "reasonable fee" for the copying of medical records. Because only 40 percent of the copies made by hospitals are billable, all hospitals would lose a significant amount of money each year as the total cost of the copying operation would not be reimbursed. This fact is demonstrated in the following Table, based on the actual cost per page by each hospital geographical type and the number of billable requests.

TABLE 1. *Summary* of *projected annual loss for hospitals based on a charge of $1. 11/page for billable requests versus the actual total annual cost of copying medical records.*

	Hospitals with Copy Service			Hospitals with no Copy Service		
	Urban	Small Urban	Rural	Urban	Small Urban	Rural
Actual cost/request *(cost/page x pages/request)*	$14.08	$14.80	$9.57	$16.35	$18.70	$14.88
Total number of requests/year	6623	3334	1214	9385	1705	907
Total actual cost/year	$93,252	$49,343	$11,618-	$153,444	$31,883	$13,491
Billable charges/request @ $1.11/pg *($1.11 x pages/request)*	$24.42	$22.20	$16.10	$16.65	$18.88	$9.71
Number of billable requests/year *(total requests x 96 billable)*	2556	1300	480	2834	665	479
Total amount billable/year *(billable charges/request x # billable)*	$62,418	$28,866	$7,720	$47,190	$12,554	$4,652
Projected loss/year *(tot actual cost – tot billable charges)*	$30,834	$20,477	$3,898	$106,254	$19,329	$8,839

Based upon a legislated fee of $1.11 per page, hospitals could lose anywhere from $3,898 per year in a rural hospital with a R.O.I. service company to $106,254 per year in an urban hospital with no R.O.I. service company. While a loss of $3,898 may seem minimal, one must remember that all statistics have been calculated on median results. Since the median represents the midpoint, significantly higher losses would occur for half the hospitals responding to this study.

IMPACT OF LEGISLATED FEES

The passage of legislation specifying fees that hospitals can charge for copies of medical records in Ohio is of great concern to Ohio hospitals and medical record/health information management professionals. As this study points out, there is great variability among hospitals with regard to the cost of copying medical records. In an era where hospitals are continuously faced with decreased reimbursement from federal and state programs along with other third party payor revenue losses, passage of legislated fees for medical record copies that do not cover the cost of the entire copying function could be devastating to patients and the health care industry. As specified earlier, only 40 percent of the requests for copies are considered billable today. Charges for copies are based upon the total cost of providing the copy function. Individuals that receive copies of records for direct patient care currently receive them free of charge. While each hospital would choose to respond to inadequate legislated fees in accordance with their financial position and business philosophy, some of the likely responses and effects on hospitals are discussed below.

Increased hospital charges

Just as hospitals shift the costs of health care from those segments of the population that do not adequately reimburse services (e.g. Medicare, Medicaid, and other charity care) to commercial third party payors through the increase of hospital prices, it is likely that many hospitals will choose to increase hospital

charges accordingly to make up for the losses in copy revenue. Because a high percentage of hospital reimbursement is in accordance with fixed fee schedules, hospitals can raise prices anytime and to whatever level necessary. The segment of commercial payors that reimburses hospitals on a fee-for-service basis is shrinking. Therefore, health care costs will increase for that small segment only, further contributing to the problem that is driving health care reform at the state and national levels.

Decrease in level of service and delays in patient care

Just as in any other business, services provided by hospitals that "pay for themselves" or make a profit receive the necessary financial support in terms of staffing, equipment, and other items necessary to make the service run efficiently and effectively. Because the current charging practices for copies of medical records fund the copy function, department directors could be forced to reduce staff and hold off on equipment replacements if the function could no longer support itself. Such action would significantly decrease the current level of service and timeliness for providing copies of medical records. First to feel the effects of a backlogged operation would be non-medical requestors (insurance companies, attorneys, and government agencies). Eventually, medical requestors (physicians, home health, nursing home transfers, cancer patient follow-up care, etc.) would also be affected by the reduced ability to provide this service. This scenario raises serious quality of care concerns if scarce manpower and limited resources lead to backlogs which interfere with the timely receipt of a patient's medical record for use in follow-up care. Providing continued care in the absence of documentation about prior treatments puts both the patient and the health care provider at risk and adds to the cost of health care in the form of repeated unnecessary tests, etc.

Charging for patient care requests

Although it has been standard practice among hospitals to furnish copies of medical records to other health care providers for purposes of continuing care at no cost, hospitals may be forced to discontinue this professional courtesy. It is in the best interest of the patient for hospitals to continue the practice of providing free copies for continuing care as the patient can be assured that his/her health care provider will receive the records in a timely fashion. The mechanisms for charging and collecting fees for patient care copies would only impede and place unnecessary strain on the patient care process. In addition, it could lead to quality of care issues if health care providers felt that the fees charged represented an unnecessary business expense and chose to obtain all previous health care information verbally through the patient. The timeliness and quality of information would be dramatically impacted if hospitals resorted to this solution to recoup copy cost losses.

Discontinue or renegotiate outsourcing arrangements

As mentioned earlier, outsourcing the medical record copy function has been a way many hospitals have been able to get medical information processed in a timely and fiscally responsible manner. R.O.I. service companies must be able to profit to survive. Legislating a fee structure that does not account for the total cost of the copy function will force R.O.I. service companies into renegotiations with hospitals. R.O.I. service companies make their profit on the efficiencies they have established through specialization and volume equipment purchasing arrangements. However, the revenue stream available to the R.O.I. service company must be equal to or greater than the hospital's cost of the entire copy function. At the present time, R.O.I. service companies handle all requests for information, not just the reimbursable requests. Contract renegotiations would likely limit the services provided to only billable accounts or require that the hospital pay a fee for copies which are non-billable. Whether hospitals chose to renegotiate one of the above possibilities or discontinue outsourcing, they would have to deal with a legislatively induced financial burden.

Increased risk of confidentiality/security breaches

Hospitals have a duty to protect patient medical records from unauthorized access. As discussed earlier, there are numerous federal and state confidentiality requirements that must be adhered to by personnel charged with the responsibility for releasing patient information. In a cost-constrained environment, hospitals may be

forced to lower standards for personnel hired to perform copy activities in an attempt to reduce the fixed cost associated with the copy function. While most hospitals would not wish to assume the risk associated with employing untrained personnel, under problematic financial circumstances they may have no choice. Even if credentialed-trained personnel remained employed in the function, pressures to produce more with less staff would be present. As with any job performed by humans, pressures to produce more than current procedures allow result in modifications and shortcuts to the procedures. Procedures related to confidentiality and security of patient information cannot undergo shortcuts without adverse effects.

Increased accounts receivables

It is inevitable that inappropriately legislated fees would result in backlogs of copy requests. Backlogs in processing requests for third party payors would impact continuity of care. As a result, they would adversely affecting health care, and create reduced, delayed, or denied payments to hospitals and other health care providers associated with the hospital, such as physicians and therapists. This negatively affects the hospital's accounts receivables. Not only would hospitals lose revenue from medical record copies, but they would also lose revenue through an increase in accounts receivables. Ultimately, the patient bears the burden of this negative impact on health care costs.

Inability to respond to health care reform requirements

Health care reform models are currently the topic of much debate. From the perspective of Ohio medical record/health information managers, reform is clearly already well underway. Two components of health care reform that hospital medical record/health information managers are intimately involved with include information requirements related to managed care contracts and the development of computer-based patient record systems. While the ultimate outcome of these reform measures will be to reduce the cost of health care, initial start-up costs are high. Reduction of revenue from medical record copies today will not assist hospitals in developing and implementing new technology that will tremendously reduce health care costs in the future.

Managed Care Information Systems. An increasingly larger share of patients seen at Ohio hospitals have their health care coverage provided as part of a managed care contract. The employers and insurers of these patients are seeking care of the highest quality at the lowest cost possible. How do these employers and insurers determine who has the highest quality and lowest cost for their patient population?

One factor in the decision making process relies on obtaining accurate and timely data from hospital medical record/health information managers. Medical record/health information managers are developing systems to facilitate the analysis of data for patient outcomes, including clinical outcomes, patient satisfaction with their care, patient function following their hospital stay; and financial outcomes. Hospital resources are required to develop and maintain these systems: These functions are critical both to ensuring the quality of care and to enabling hospitals to remain financially viable.

Computer-based patient record systems. A second component of health care reform is the need for major changes in the way health care information is obtained, managed, and used. What is needed is a computer-based patient record. New information systems are under development to allow for the electronic documentation of all clinical encounters, standardization of information collected, and even regional electronic data networks. Such systems are crucial for consumers, the government, and private industry to be able to monitor and evaluate the health care system, assess the quality of care, simplify administration, and identify fraud and waste. Patient records will become longitudinal, i.e., they will be comprehensive, readily accessible collections of patient information from the patient's birth to death. Computer-based patient records will enable hospitals to care for patients more effectively, and the release of patient information will also be simplified due to easier access to the patient information. Medical record/health information managers will have an even greater duty, however, to ensure the integrity and security of computer based patient information. According to a recent Louis Harris poll, for the first time in 23 years, a majority of Americans are concerned about their

privacy. Hospitals and health insurance companies top the list of businesses where Americans most feel their privacy should be protected.

The cost of implementing computer-based records in hospitals is difficult to pinpoint. The Institute of Medicine has estimated costs at around $2-$6 million for a medium-sized hospital. The Health Care Financing Administration has estimated a cost of $10,000 per hospital bed. Obviously, hospitals must make a hefty financial commitment in order to begin building their computer-based patient record systems. Once universally implemented, in addition to improving the quality of health care, a recent study published by Arthur D. Little, Inc., has projected annual savings to the United States of nearly $30 billion in the delivery of health care.

CONCLUSION

Although the study provides a wealth of information on costs of the release of information function in Ohio hospitals, the legislation of fees in this regard is still a complex issue with far reaching implications to hospitals in the delivery of quality health care at an affordable price. As discussed previously, hospitals need to cover the cost of providing the service in total so as not to adversely impact the patient care process and increase costs. While current practices of passing on the cost of the entire function to only 40 percent of the requestors may seem unfair, it is consistent with how hospitals are reimbursed for their services today. Because the cost of charity care is not fully reimbursed, the cost of health care is increased for those that have the means to pay for it. Until the health care system is restructured under health care reform, it is premature to legislate any type of charge limitations for medical record copies that do not ensure reimbursement of all costs incurred in the provision of the hospital release of information function in its entirety.

The medical record is the who, what, why, where, when, and how of patient care. Its primary purpose is to provide a means of communication between the physician and other professionals contributing to the patient's care and to serve as a basis for planning individual patient care. Hospitals nationwide have traditionally provided copies of medical records for purposes of continuing care free of charge as this practice is in the best interest of all patients. For obvious reasons, almost everyone would like for this practice to remain untouched. While governmental entities such as Medicare and Medicaid are requesting and using the medical record for purposes other than direct patient care, hospitals are prohibited by law from collecting fees for these requests (Medicare does reimburse hospitals seven cents a page). The 60 percent figure obtained in the study for nonbillable requests may seem high but is consistent with other national and state studies.

The median per-page cost figures identified in the study are underestimated and identify the median cost for each page produced in the entire release of information function. If the median cost per page of $1.11 was used as a basis for a legislated fee, with an additional 30 percent added for costs not included in the study, the median fee per page would become $1.44. The $1.44 represents the median cost per page for each page produced for all requests. To remain consistent with current cost shifting practices in health care and in the release of information function, the per page median cost would have to be increased another 60 percent to cover the nonbillable portion of the service, bringing the median cost per page to $2.30. However, as one examines the variability in costs to handle the release of information function among hospitals within the State, it is obvious that this issue defies a flat, per page, legislated fee. Even if a figure of $2.30 per page was used, this arrangement places one-half of the hospitals in a position to make a profit and the other half in a position to lose money, with a small portion in the middle just "breaking even." Legislation that immediately creates winning and losing hospitals does not seem to be the appropriate way of handling the concern at hand.

While the Ohio Health Information Management Association believes that the free market system has created fee structures for copies of medical records that are appropriate and in line with actual costs, we do understand that there are those who still feel that they are unfair. Perhaps the best way to handle the concern is through the legislative process. However, one can certainly see the difficulties and perhaps inappropriateness of trying to determine fair and equitable legislation in terms of a set fee structure for all hospitals, or at least for the

majority of all hospitals. As described in this report, any legislation in this regard must strive to ensure that all costs of the release of information function are covered, including:

1) all labor costs associated with the tasks described on pages 3 through 10 of this report;

2) actual costs of materials and equipment (i.e.: computer hardware and software, copy machines and other duplicating equipment, paper, toner, and routine maintenance);

3) mailing or delivery expenses;

4) billing and bad debt expenses; and

5) overhead expenses (i.e. space expense for the function, supervisory overhead, depreciation expense, etc.).

If it is the feeling of the Legislature, after careful examination of this report, that legislation to address the issue of fees for copies of medical records is necessary, the Ohio Health Information Management Association would be happy to assist you in such development.